Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMAN HOSPITAL
3200 SW FREEWAY STE 2200
HOUSTON TX 77027

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-08-6378-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The amount paid by the carrier falls below the hospital's expected reimbursement rate. My client expected a fair and reasonable reimbursement since there is no particular fee guideline establishing a maximum amount recoverable under the Acute Care Inpatient Hospital Fee Guideline (ACIHFG) found in Commission Rule 134.401. Because this admit was for trauma/burn falling within diagnostic codes ICD9-800.0 – 959.5, the entire admission should be reimbursed at a fair and reasonable rate under Rule 134.401(c)(5). The carrier instead paid the claim under an unknown methodology, which resulted in approximate 16% reimbursement rate for treatment of this major trauma patient. A reduction in excess of 84% of the hospital's usual and customary charges on its face inherently unreasonable, especially for treatment of a severe trauma victim. It is the hospital's position that a unilateral arbitrary reduction of its usual and customary charges by over 94% is inherently unfair and unacceptable from a commercial insurance company. Even negotiated managed care rates provide reimbursement levels much higher that [sic] 16%, especially when charges are incurred for a trauma admit. Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred"

Amount in Dispute: $19,087.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute concerns the appropriate payment amount for hospital outpatient services absent a fee guideline amount for date of service 6/30/07 to 7/2/07. The requester billed $27,761.50; Texas Mutual paid $3,680.45. The requester believes it is entitled to an additional $17,087.05. The requestor billed Texas Mutual an outpatient admission, date 6/30/2007 – 7/2/2007. (There is no room and board charges included with this billing.)… The new fee guideline states that $200% of the OPPS payment is the MAR, which DWC presumes is fair and reasonable. The requestor's billed codes at two hundred percent of Medicare pays at $3,587.30. Texas Mutual paid $3,680.45, which it believes if more than fair and reasonable for the treatment rendered. The requestor proposes a total reimbursement of 100% of billed charges. Texas Mutual believes the requestor has failed to show Texas Mutual's payment amount is not fair and reasonable nor has the requestor demonstrated its proposed payment is. In the absence of such demonstration Texas Mutual asserts no additional payment is due."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 30 thru July 2, 2007	Outpatient Surgery	$19,087.05	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on June 26, 2008.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W10 – No maximum allowable defined by the fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - 97 – Payment is included in the allowance for another service/procedure.
   - 217 – The value of this procedure is included in the allowance for another procedure performed on this date.
   - 426 – Reimbursed to fair and reasonable.
   - 18 – Duplicate claim/service.
   - 224 – Duplicate charge.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - 891 – The insurance company is reducing or denying payment after reconsideration.

Findings

1. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It

further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

3. 28 Texas Administrative Code §133.307(c)(2)(E), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has provided copies of all medical records pertinent to support the 53 hour observation services in dispute. The Division concludes that the requestor has met the requirements of §133.307(c)(2)(E).
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - Requestor submits that a fair and reasonable rate for treatment of this injured employee is the usual and customary charges incurred.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 26, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.